Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012891	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MONONA CBRF	111 OWEN RD MONONA, WI 53716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 09/22/2025, Surveyors conducted a standard survey and three (3) complaint investigations at Heritage Monona CBRF. One deficiency was identified. Two of 3 complaints were substantiated. Census: 27	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents received adequate supervision and eloped from the secured facility. Resident 2 exited from the secured facility 2 times and was found walking on the sidewalk outside of the facility. Resident 7 exited from the secured facility and his/her friend returned him/her back to the facility after picking him/her up from a business off facility grounds.	N 426		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 426	Continued From page 1 The supervision for Resident 1 was not adequate on the following dates: On 07/08/2025, Resident 1 slapped Resident 6 in the face. On 07/21/2025, Resident 1 slipped Resident 2, twice. On 07/28/2025, Resident 1 punched Resident 6 on [his/her] upper arm. On 08/16/2025, Resident 1 punched Resident 5 in side of the head. On 08/25/2025, Resident 1 threw coffee onto Resident 2. On 08/27/2025, Resident 1 punched Resident 4 in the face. On 09/10/2025, Resident 1 went into Resident 3's room and punched (him/her) in the face. Findings include: Example 1 - Elopements On 09/22/2025, Surveyors conducted a standard survey and 3 complaint investigations. The provider is licensed as a class CNA (non ambulatory) community based residential facility (CBRF) able to serve up to 39 residents within the client group of irreversible dementia/Alzheimer's. The provider's program statement states the facility's services include a state-of-the-art security system is in place in memory care to prevent any wandering away from the facility. On 09/22/2025 at 8:30 a.m., Surveyor interviewed Caregiver D and asked if the facility had any residents that were elopement risks. Caregiver D stated that Resident 2 had wandering/elopement risks in the last few weeks. Caregiver D stated that "Resident 2 will stand by the front door and	N 426		

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watch for people to come in and out." Caregiver D stated that the staff try to redirect Resident 2 with activities.

On 09/22/2025 at 9:30 a.m., Surveyors reviewed the department's facility's records. The record included 3 self-reports of elopement from 07/10/2025 through 09/14/2025. The reports indicated the following:

-Self report, dated 07/15/2025, stated Resident 7 was "seen in the dining room by staff around 4:11 p.m. At 4:51 p.m. the resident's friend received a phone call from [him/her] stating that [s/he] was at [business] and would like a ride home. The [friend] picked Resident 7 up at 5:13 p.m. and returned him/her back to the facility." Code to memory doors was changed for safety.
-Self report, dated 09/10/2025, stated Resident 2 "ambulates independently without the use of assistive devices and has a history of exit seeking behavior. Staff observed resident at approximately 9:55am after obtaining [his/her] weight. At approximately 10:25a (sic) resident was observed walking on the sidewalk in front of the facility by a staff member who was on break." Resident 2 was safely and easily returned to the memory care unit without issue.
-Self report, dated 09/17/2025, stated Resident 2 "ambulates independently without the use of assistive devices and has a history of exit seeking behavior. Staff last observed resident at approximately 6:00pm after dinner ambulating at baseline. At approximately 6:25pm resident was observed walking on the sidewalk on the side of the building by a staff member who was on break. Initial attempt to redirect resident back to unit was unsuccessful with resident stating [s/he] was "going to my home on [street name]". Staff member remained walking with resident to

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ensure safety and alerted on duty staff. Resident was subsequently redirected to the memory care unit safely without further incident."

On 09/22/2025 at 12:30 p.m., Surveyor reviewed resident records that documented the following for Resident 2 and Resident 7:

-Resident 2 -

Resident 2 was admitted to the provider's facility on 07/02/2025 with diagnosis of dementia and Alzheimer's disease. Resident 2's pre-admission assessment identified him/her as an elopement/wandering risk. Resident 2's individual service plan (ISP), dated 08/05/2025, identified his/her behaviors as: anxiety, dementia, exit seeking and physical aggression. Behavior interventions stated in the plan for exit seeking behaviors:

-Dated 09/14/2025, plan stated Update resident's engagement bin with additional activities of interest along with changing code for the MC Door.
-Dated 09/06/2025, plan stated when resident is actively exit seeking, staff will attempt to engage in activities of interest.

-Resident 7 -

Resident 7 was admitted to the provider's facility on 07/07/2025 with a diagnosis of dementia. Resident 7's ISP dated 08/05/2025 identified him/her as a wandering risk. The wander risk interventions stated in plan: 1 hour wellness check while awake and distract from wandering by offering pleasant diversions, food, conversation, television or books.

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N 426	Continued From page 4 On 09/22/2025 at 4:55 p.m., Surveyors reviewed the concern of adequate supervision with 2 residents eloping from a secured area 3 times from 07/10/2025 to 09/14/2025 with Executive Director A, Assist Director of Nursing B and Nursing C. Executive Director A stated that the facility was not aware of how Resident 2, or Resident 7 exited the secured area. Executive Director A stated that the memory care door code had been changed and both Resident 2 and Resident 7 had updated ISP's with interventions for leaving the facility. Example 2 - Aggression At 8:40 a.m., Surveyor interviewed Executive Director A and asked if any of the residents display aggressive behavior. Executive Director A stats that Resident 1 has been aggressive, and his/her family comes to sit with him/her in the evenings. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/14/2025 with diagnoses including delusional disorder, dementia with behavioral disturbances, depression and insomnia. Surveyor reviewed Resident 1's individual service plan (ISP), dated 06/13/2025, which documented the following for Resident 1's behaviors: -Family to provider 1:1 during peak behavior times -Resident moved apartments -Resident to sit at a table nearest kitchenette -Staff to step away, alternate staff member to assist with redirecting resident to quiet location -Hospice to schedule Geri-psych consult -Behavior Management plan created and discussed -Keep residents separated	N 426		

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N 426	Continued From page 5 -Staff to redirect resident when they notice resident becoming agitated - increased pacing, mumbling, yelling or shouting -Move residents table away from other residents Surveyor reviewed Resident 1's progress notes which documented: -07/08/2025, "Resident is observed slapping another resident in the face." -07/08/2025, "Resident was observed grabbing another resident's food. When staff approached resident to redirect resident punch staff in the face." -07/11/2025, "Resident agitated in dining room, yelling at other residents, attempting to take food." -07/21/2025, "Staff report another resident (resident A) approached resident (resident B) in dining room around 1730 asking where [his/her] keys were. Resident B stated [s/he] didn't have them, resident A slapped [him/her]. Staff separated residents and directed away from each other. A short time later, resident A again approached resident B in dining room to ask where [his/her] keys were, resident B stated [s/he] didn't have them, resident A slapped resident B. Resident B punched resident A." -07/25/2025, "Resident and peer were in dining room. Both residents began increasing verbal aggression towards each other and calling each other names. Resident were told by staff to top. Redirection did not work and first and residents became to shove each other and punch each others[sic] shoulders. Staff then redirected residents and separated the residents from each other." -07/28/2025, "Staff reported that resident A approached another resident in common area near dining room and resident B yelled at resident to stop. Resident A punched resident B on	N 426		

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[his/her] upper arm and then resident B punched resident A on [his/her] upper arm.
-08/16/2025, "Resident punched another resident on side of head in dining room."
-08/25/2025, "Resident was agitated and threw coffee onto another resident."
-08/27/2025, "Staff responded to another resident (resident B) shouting for help. Resident (resident A) shoved resident B after attempting to enter resident B's apartment. Resident B [s/he] answered a knock at [his/her] door and when [s/he] answered resident A said it was [his/her] apartment, when [s/he] opened door to show [him/her his/her] name plate, resident A shoved [him/her]."
-08/27/2025, "Staff report responded to a residents (resident B and c] shouting for help. Staff observed resident A punch resident B, resident C heard yelling at resident A to stop."
-09/10/2025, "Resident went into another resident's room and punched other resident L side of face"
-09/19/2025, "Punched another Resident"

Surveyor reviewed the record of Resident 2. Resident 2 was admitted to the provider's facility on 07/02/2025 with diagnosis of dementia and Alzheimer's disease. Resident 2's progress notes documented:
-07/21/2025, "Staff report another resident [Resident 1] approached resident [Resident 2] in dining room around 1730 asking where [his/her] keys were. [Resident 2] stated [s/he] didn't have them, [Resident 1] slapped [him/her]. Staff separated residents and directed away from each other. A short time later, [Resident 1] again approached [Resident 2] in dining room to ask where [his/her] keys were, [Resident 2] stated [s/he] didn't have them, [Resident 1] slapped [Resident 2]. [Resident 2] punched [Resident 1]."

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-07/25/2025, "Resident and peer were in dining room. Both residents began increasing verbal aggression towards each other and calling each other names. Resident were told by staff to top. Redirection did not work and first and residents began to shove each other and punch each others[sic] shoulders. Staff then redirected residents from each other. Peer went back to [his/her] room with staff and resident walked away from resident. No injuries noted."

Surveyor reviewed the record of Resident 3. Resident 3 was admitted to the provider's facility on 03/25/2025 with diagnoses including dementia, epilepsy and depression. Resident 3's progress notes documented physical aggression was received (from Resident 1) on 09/10/2025, "Resident was laying in bed and another resident came into [his/her] room and punched [him/her] on the L side of [his/her] face. Bruise noted to L side of face."

Surveyor reviewed the record of Resident 4. Resident 4 was admitted to the provider's facility on 05/09/2025 with diagnoses including Alzheimer's and depression. Resident 4's progress notes documented physical aggression was received (from Resident 1) on 08/27/2025, "Staff responded to residents shouting for help. Staff observed [Resident 1] punching [Resident 4] sitting in [his/her] wheelchair directly outside [Resident 1's] apartment. Resident C calling for help. Resident unable to articulate what happened. Bruising observed to bilat[sic] cheekbones and bruising/swelling noted to left temple. C/O (complained of) pain/tenderness to face, rates 10/10."

On 09/22/2025 at approximately 11:30 a.m., Surveyor interviewed Caregiver E. Caregiver E

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N 426	Continued From page 8 stated that Resident 1 had hit a few residents. Caregiver E stated that Resident 1 has gone after people like Resident 3 and Resident 4 because they are in a wheelchair or bed. Caregiver E said that Resident 1 starts to get angry right after lunch time and staff try to calm him/her down. Caregiver E stated that Resident 1 will start frowning and get a crease around his/her brow area when s/he is getting upset. Caregiver E stated that s/he has tried to redirect and offered medication if it is needed. On 09/22/2025 at 4:40 p.m., Executive Director A confirmed that the incidents documented in Resident 1's record on 07/08/2025 and 07/28/2025 involved Resident 1 aggressing upon Resident 6 and that the incident on 08/16/2025 involved Resident 1 aggressing upon Resident 5. On 09/22/2025 at 4:55 p.m., Surveyors reviewed the concern of resident safety with Executive Director A, Assist Director of Nursing B and Nursing C. Nursing C stated that s/he understands the concerns but did note that there have been interventions put in place that have decreased the physical aggression of Resident 1.	N 426		